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State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
IN-PATIENT HOSPITAL CARE

C. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicaid cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

D. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the non-enrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

E. Prior approval must be received from DMAS when a referral has been made for treatment to be received from a non-enrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

F. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for the services on an individually, negotiated rate basis.

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XIII. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of five million dollars in General funds and its corresponding federal financial participation for reimbursement to non-state owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each non-state owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to the State Plan, Attachment 4.19A, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Fund shall be disbursed in accordance with the following methodology:

1. Identify each non-state owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.

2. For each such hospital identified in Paragraph 1, identify its Medicaid paid days for the 12 months ending each May 31.

3. Multiply each such hospital's days under Paragraph 2 by such hospital's May individual peer group ceiling (i.e., disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.

4. Sum all hospital amounts determined in Paragraph 3.

5. For each such hospital, divide its amount determined in Paragraph 3 by the total of such amounts determined in Paragraph 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.

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6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in Paragraph 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the mid-point of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in Paragraph 2 above, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's unreimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an unreimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an unreimbursed amount balance.

11. Recompute each hospital's new potential share of the undisbursed PAF by multiplying such finds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its unreimbursed amount. If the unreimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' unreimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their unreimbursed amount as their actual PAF share. Then, for those hospitals with an unreimbursed amount balance, repeat steps 10, 11, and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each non-state owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonable feasible.